(c) If the department, after review of the documentation submitted during the sixty-day period, determines that the records are still unauditable, the department shall terminate the facility from the medicaid program pursuant to Chapter 119. of the Revised Code.

(d) Refusing legal access to fiscal, statistical, or medical and program records results in an immediate suspension of payment for outstanding medical services until such time as the requested information is made available.

(C) Rates will be established for a rate year of July first through June thirtieth.

(1) The rate of payment to ~~LTCFs~~ NFS WITH LOW MEDICAID UTILIZATION identified in paragraphs (A)(1) and (A)(2) of this rule is the statewide average reimbursement rate CALCULATED for all ~~such~~ NURSING facilities ~~(ICF, SNF, SNF/ICF)~~ FROM ~~in~~ the sample selected under division (D) of section 5111.27 of the Revised Code for the prior cost report year UPDATED WITH INFLATION or the ~~LTCF's~~ NF'S charge to NONMEDICAID INDIVIDUALS FOR THE SAME SERVICES DURING THE CORRESPONDING TIME PERIOD ~~residents who are not recipients under the medicaid program~~, whichever is less.

~~Until such time as the number of certified providers of only SNF care exceeds ten per cent of all LTCFs in Ohio, the statewide average rate for SNFs will be the SWA rate for SNF/ICFs in the specified sample.~~

~~(2) For those facilities paid under paragraph (A)(3) of this rule, rates will be established based on the statewide average reimbursement rate for ICFs MR in the audit sample selected according to division (D) of section 5111.27 of the Revised Code as follows:~~

~~(a) For facilities where two-thirds or more of the residents are blind, deaf, actively seizure prone, nonambulatory, mobile nonambulatory, aggressive, assaultive, security risks, or severely hyperactive or psychotic-like in behavior, the rate will be determined by the following chart based upon the needs of the residents for twenty-four-hour awake and on-duty staffing as identified by the additional "Specialized Services Tool" (ODPW ODHS 3406).~~

TNS # 90-48 APPROVAL DATE 2/5/91
SUPERSEDES
TNS # 90-11 EFFECTIVE DATE 12/31/90

(2) THE FOLLOWING RATES OF PAYMENT ARE ESTABLISHED FOR ICF-MR FACILITIES WITH EIGHT BEDS OR LESS. THEY ARE BASED UPON THE STATEWIDE AVERAGE REIMBURSEMENT RATE CALCULATED FOR ICF-MR FROM THE AUDIT SAMPLE SELECTED ACCORDING TO DIVISION (D) OF SECTION 5111.27 OF THE REVISED CODE. ALL PAYMENT RATES ARE LIMITED BY THE RATE PAID BY NONMEDICAID INDIVIDUALS FOR THE SAME SERVICES DURING THE CORRESPONDING TIME PERIOD, IF SUCH RATE IS LOWER.

(a) RATE "A" IS ESTABLISHED AT ONE HUNDRED THIRTY PER CENT OF THE STATEWIDE AVERAGE ICF-MR REIMBURSEMENT RATE. THIS RATE AS ILLUSTRATED IN THE RATE TABLE APPLIES IN THE FOLLOWING CIRCUMSTANCES:

(i) IN FACILITIES WITH FIVE OR MORE RESIDENTS WHO MEET OR EXCEED CRITERIA SPECIFIED IN PARAGRAPH (C)(2)(b) OF THIS RULE WHERE AT LEAST THREE RESIDENTS REQUIRE TWENTY-FOUR-HOUR SUPERVISION.

(ii) IN FACILITIES WITH THREE OR FOUR RESIDENTS WHO MEET OR EXCEED CRITERIA SPECIFIED IN PARAGRAPH (C)(2)(b) OF THIS RULE WHERE AT LEAST TWO RESIDENTS REQUIRE TWENTY-FOUR-HOUR SUPERVISION.

(iii) IN FACILITIES WITH TWO RESIDENTS WHO MEET OR EXCEED CRITERIA SPECIFIED IN PARAGRAPH (C)(2)(b) OF THIS RULE WHERE AT LEAST ONE RESIDENT REQUIRES TWENTY-FOUR-HOUR SUPERVISION.

(iv) IN FACILITIES WITH ONE RESIDENT WHO MEETS OR EXCEEDS CRITERIA SPECIFIED IN PARAGRAPH (C)(2)(b) OF THIS RULE WHERE THAT RESIDENT REQUIRES TWENTY-FOUR-HOUR SUPERVISION.

(b) RATE "B" IS ESTABLISHED AT ONE HUNDRED FIFTEEN PER CENT OF THE STATEWIDE AVERAGE ICF-MR REIMBURSEMENT RATE (SEE RATE TABLE IN PARAGRAPH (C)(2)(c) OF THIS RULE). RATE "B" IS PAID TO FACILITIES WHERE TWO-THIRDS OR MORE OF THE RESIDENTS ARE BLIND, DEAF, ACTIVELY SEIZURE PRONE, NONAMBULATORY, MOBILE NONAMBULATORY, AGGRESSIVE, ASSAULTIVE, SECURITY RISKS OR SEVERELY HYPERACTIVE OR PSYCHOTIC-LIKE IN BEHAVIOR BASED UPON THE SPECIAL NEEDS OF THE RESIDENTS AND STAFF INTERVENTIONS DOCUMENTED BY ODHS 3406.

"Two-thirds" is defined as one resident out of a one- or two-resident facility; two residents out of a three-resident facility, three residents out of a four- or five-resident facility, four residents out of a six-resident facility, five residents out of a seven- or eight-resident facility.

(c) RATE "C" IS ESTABLISHED AT ONE HUNDRED PER CENT OF THE STATEWIDE AVERAGE REIMBURSEMENT RATE FOR ICF-MR FACILITIES WHICH HAVE RESIDENTS WHO DO NOT HAVE SPECIAL NEEDS AND DO NOT MEET THE CRITERIA SPECIFIED IN PARAGRAPHS (C)(2)(a) AND (C)(2)(b) OF THIS RULE.

TNS # 90-11 EFFECTIVE DATE 12/1/90
SUPERSEDES
TNS # 90-18 APPROVAL DATE 1/5/91

REIMBURSEMENT RATE TABLE FOR ICF-MR FACILITIES WITH EIGHT BEDS AND UNDER

		Number of residents who meet the twenty-four hour need standards								
		0	1	2	3	4	5	6	7	8
Number of facility residents	1	B	A							
	2	B	A	A						
	3	B	B	A	A					
	4	B	B	A	A	A				
	5	B	B	B	A	A	A			
	6	B	B	B	A	A	A	A		
	7	B	B	B	A	A	A	A	A	
	8	B	B	B	A	A	A	A	A	A

~~(i) Rate A is one hundred thirty per cent of the statewide average rates.~~

~~(ii) Rate B is one hundred fifteen per cent of the statewide average rates.~~

~~(b) For those facilities which do not meet the criteria in paragraph (C)(2)(a) of this rule, the rate is the statewide average rate.~~

(d)~~(c)~~ The rates established in paragraph (C)(2)(a), ~~or~~ (C)(2)(b) OR (C)(2)(c) of this rule ARE PAID AS INTERIM RATES TO NEW FACILITIES OR TO FACILITIES THAT HAVE ESTABLISHED COST IN EXCESS OF NINETY-THREE PER CENT OF RATES "A", "B", OR "C" WHICHEVER IS APPLICABLE. FACILITIES WITH PER DIEM COST BELOW OR EQUAL TO NINETY-THREE PER CENT OF RATES "A", "B", OR "C", WHICHEVER IS APPLICABLE, ARE PAID WITH RATES ESTABLISHED AT ONE-HUNDRED-SEVEN PER CENT OF FILED COST UPDATED WITH AN INFLATION FACTOR. ~~will be reduced to the rate paid by residents who are not recipients of medicaid if such charges are lower.~~

(e) FOR FINAL SETTLEMENT PURPOSES, REPORTED COST IS AUDITED AND COMPARED TO RATES "A", "B", OR "C". IF ALLOWABLE PER DIEM COST IS LESS THAN OR EQUAL TO NINETY-THREE PER CENT OF RATES "A", "B", OR "C", THE SETTLEMENT RATE IS CALCULATED AT ONE-HUNDRED-SEVEN PER CENT OF ALLOWABLE COST. IF COSTS ARE ABOVE NINETY-THREE PER CENT, THE FINAL SETTLEMENT RATE IS RATE "A", "B", OR "C" ESTABLISHED IN PARAGRAPH (C)(2)(a), (C)(2)(b), OR (C)(2)(c) OF THIS RULE, WHICHEVER IS APPLICABLE.

TNS # 90-48 APPROVAL DATE 2/5/91
SUPERSEDES
TNS # 90-11 EFFECTIVE DATE 12/31/90

~~(d) If the costs reported by an ICF-MR in paragraph (B) of this rule for a cost report year are less than ninety-three per cent of the statewide average rate for that year, the rate of payments to that ICF-MR will be adjusted to one hundred seven per cent of costs as reported and desk audited.~~

(f)~~(e)~~ Each ICF-MR of eight beds or less will be designated as eligible for the rate established under paragraph (C)(2)(a)~~(i)~~, (C)(2)~~(a)(ii)~~(b), or (C)(2)~~(b)~~(c) of this rule at the time of certification and twice each year thereafter within sixty days of each utilization control survey performed under rule 5101:3-3-15 of the Administrative Code.

(g)~~(f)~~ All facilities identified under paragraph (A)(3) of this rule shall complete the additional "Specialized Services Tool" (~~ODPW~~ ODHS 3406) on all residents at the time of admission or before the initial certification survey and at least once every six months thereafter. ODHS 3407 FORMS COMPLETED AT THE TIME OF ADMISSION OR BEFORE THE INITIAL CERTIFICATION SURVEY MAY BE SUBMITTED TO ODHS WITH THE PROJECTED COST REPORT. THESE FORMS WILL BE USED TO DETERMINE THE APPROPRIATE RATE PURSUANT TO PARAGRAPH (A)(2) OF THIS RULE, SUBJECT TO VERIFICATION BY THE BUREAU OF RESIDENT SERVICES.

(h)~~(g)~~ The department reserves the right to audit and cost settle the ICFs-MR which received payment under this rule at any time.

(3) If during the inspection of care and continued stay review performed according to rule 5101:3-3-15 of the Administrative Code and paragraph (K) of this rule, inadequate standards of care are in evidence in any facility reimbursed under this rule, the facility shall be required to meet the standards in ~~rule~~ RULES 5101:3-3-121 AND 5101:3-3-29 TO 5101:3-3-49 of the Administrative Code. Subsequently, a ~~patient assessment~~ RESIDENT review of all recipients will be completed according to rule 5101:3-3-12 of the Administrative Code. The ratio of underdelivered service costs to needed service costs resulting from this review will be imposed as an immediate percentage rate reduction penalty for one year or until such time as a subsequent review reflects adequate care.

(4) Except as provided in this rule, no retrospective adjustment to the rate paid to these facilities will be made.

(D) The per diem payment for routine services is payment-in-full, and no additional charge (other than the amount computed by the ~~CWD~~ CDHS as the ~~patient's~~ RESIDENT'S share) may be made to the ~~patient~~ RESIDENT, any member of the ~~patient's~~ RESIDENT'S family, or to any other source for any supplementation of the per diem.

Payment may be requested and received by the nursing home from the recipient or others for services not covered by the per diem (e.g., payment for reserving a bed in excess of the department's limits, residents' bedside telephone, etc.), but shall not be received for cost of covered items that have been disallowed as unreasonable. This does not preclude:

TNS # 90-19 APPROVAL DATE 9/5/91
SUPERSEDES
TNS # 90-11 EFFECTIVE DATE 12/31/90

(1) Seeking payment from a third-party resource for services billed in accordance with provisions detailed in rule 5101:3-1-08 of the Administrative Code when such resource payments subsequently reduce payments collected from medicaid.

(2) Other qualified providers of medical service seeking payment under medicaid for services not covered in the LTCF's per diem (e.g., dental services and other services as outlined in rule 5101:3-3-11 of the Administrative Code).

(3) Seeking payment from others for services specifically excluded under medicaid (e.g., payment for reserving a bed when the provisions of rules 5101:3-1-56 and 5101:3-3-03 of the Administrative Code do not apply; personal clothing; etc.).

(4) Contributions from public or private sources to a facility as long as these contributions are not designated for a particular ~~patient~~ RESIDENT or group of ~~patients~~ RESIDENTS.

(E) "Cost reporting period" means the period of time (usually one year) for which long-term care facilities report their actual historical costs of a prior period in accordance with the guidelines established by the department. The cost reporting period for all facilities reimbursed under this rule is the calendar year.

(F) "Rate year" means the period of time during which the calculated per diem is paid. The rate year, except for state institutions, begins with services rendered on July first (paid in August) of one year, and ends with services rendered on June thirtieth (paid in July) of the following year.

(G) "Inpatient days" means all occupied licensed bed days. Therapeutic or hospital leave days paid for by the department under rule 5101:3-3-03 of the Administrative Code are considered occupied bed days.

(H) Allowable costs which are reasonable and related to patient care (unless otherwise enumerated in 5101:3 of the Administrative Code) are those contained in the following reference material, as currently issued and updated, in the following priority:

(1) Title 42 CFR Chapter IV;

(2) The provider reimbursement manual ("HCFA Publication 15-1," previously entitled "HIM 15 Health Insurance Manual"); or

(3) Generally accepted accounting principles approved by the "American Institute of Certified Public Accountants."

(I) "Routine services" are the regular room; dietary; habilitation and nursing services; the minor medical and surgical, activities and program supplies necessary to provide the nursing and habilitation services defined in rules 5101:3-3-30 to 5101:3-3-49 of the Administrative Code; and the use of equipment and facilities. "Routine services" are:

(1) All general services including, but not limited to, administration of oxygen and related medications, handfeeding, incontinency care, tray service, enemas, routine care of feet and toenails, shampooing and grooming of hair, and care of skin, mouth, teeth, hands, and feet;

(2) Items furnished routinely and relatively uniformly to all ~~patients;~~ RESIDENTS such as ~~patient~~ RESIDENT gowns, water pitchers, basins, and bed pans;

(3) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, band-aids, antacids, aspirin, and other nonlegend drugs ordinarily kept on hand, suppositories, and tongue depressors;

(4) Items which are used by individual ~~patients~~ RESIDENTS but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment;

(5) Dietary supplements used for oral feeding, even if written as a prescription item by a physician;

(6) Laundry services including personal clothing usually worn during the day or night (washable items not requiring dry cleaning);

(7) Physical therapy, occupational therapy, speech therapy, audiology, and psychosocial services, or social work services and supplies used to provide these services other than those provided by county ~~welfare~~ department OF HUMAN SERVICES social workers or a certified community mental health center as defined in rule 5101:3-27-01 of the Administrative Code;

(8) Items as listed in "Nursing and Rest Homes Laws and Rules," published by the department of health;

(9) Services of a physician, psychologist, pharmacist, and other medical consultants in the capacity of providing overall medical direction, and the services of a physician in the periodic review of a ~~patient's~~ RESIDENT'S medical records and ~~patient~~ RESIDENT plan of care. Such services do not involve direct care provided to a ~~patient~~ RESIDENT on an individualized basis;

TNS # 90-48 APPROVAL DATE 2/5/91
SUPERSEDES
TNS # 90-11 EFFECTIVE DATE 12/31/9

(10) Reserving a bed for a ~~patient~~ RESIDENT temporarily hospitalized or on a therapeutic leave of absence as provided in rule 5101:3-3-03 of the Administrative Code.

(J) Routine services do not include the cost of prescription legend drugs; physician services other than those covered in paragraph (I)(9) of this rule; dental services; vision care services; podiatric services; ambulance services; nonreusable durable medical equipment; psychiatric services; and laboratory and x-ray services provided to a patient on an individual basis. These service costs are met by direct payment to recognized providers of these services.

(K) Twice each year the department will conduct a utilization review for inspection of care, continued stay review, AND ADVERSE PLACEMENT DETERMINATION as required by 42 CFR Subparts (E), (F), and (I) and rule 5101:3-3-15 of the Administrative Code.

(1) The review will include resident observation to identify discrepancies between the observed ~~patient's~~ RESIDENT'S condition and the resident's condition as reflected in the plan of care, or the additional specialized services tool and the services delivered by the facility as reflected in the ~~patient's~~ RESIDENT'S medical records.

(a) A referral will be made to the licensing or certification agency or other responsible agency or a follow-up visit will be made by a physician or QMRP and a supervisor of the ~~patient~~ RESIDENT ~~assessment~~ REVIEW field staff for any ~~patient~~ RESIDENT whose medical and health-related needs (as reflected in the plan of care, medical records, program notes) do not correspond to the observation of the ~~patient's~~ RESIDENT'S needs, or when despite entries in the records it appears that a service recorded as delivered has not been delivered. In these instances, there will be a consultation with the ~~patient's~~ RESIDENT'S physician, QMRP, and medical staff of the facility and the assessment of the individual will be revised according to the findings of the follow-up visit.

(b) The results of a follow-up visit to investigate the apparent discrepancies between ~~patient assessment~~ RESIDENT REVIEW staff's observation of ~~patient's~~ RESIDENT'S need and facility's service delivery and the ~~patient's~~ RESIDENT'S written plan of care, medical and program records, and staff notes (as described in paragraph (C)(3) of this rule) are appealable under provisions set forth in rule 5101:3-1-57 of the Administrative Code.

TNS #90-48 APPROVAL DATE 2/5/91
SUPERSEDES
TNS #90-11 EFFECTIVE DATE 12/31/90

(2) The reviewers will also determine the ~~patient's~~ RESIDENT'S level of care, at the time the review is conducted, based on the level of care definitions contained in rule 5101:3-3-12 of the Administrative Code. ~~In SNFs for SNF patients, the level of care entered on the patient assessment form by department patient assessment staff will, in such instances, be used only for internal management reasons.~~

(L) The department will enter into a written letter of agreement with ODH and ODMR/DD to verify the classification of new ICF-MR/DD providers under paragraph (C)(2) of this rule; to verify status of each recipient upon admissions based on the additional "Specialized Services Tool"; and to investigate problems identified in paragraph (K) of this rule.

EFFECTIVE DATE: _____

CERTIFICATION: _____

_____
DATE

Promulgated Under RC Chapter 119.
Statutory Authority RC Section 5111.02, 5111.222
Rule Amplifies RC Sections 5111.01, 5111.02, and 5111.222
Prior Effective Date: 7/1/84, 10/1/90 (Emer.)

TNS #90-48 APPROVAL DATE 9/5/91
SUPERSEDES
TNS #90-11 EFFECTIVE DATE 12/31/90

5101:3-3-75 Intermediate care facilities for the mentally retarded (ICF-MR) case mix assessment instrument: Individual Assessment Form (IAF).

(A) For the purpose of determining medicaid payment rates for intermediate care facilities for the mentally retarded (ICFs-MR) effective July 1, 1993 and thereafter, each ICF-MR shall assess all residents of medicaid-certified beds, defined in paragraph (B) of this rule, ~~quarterly~~ AT LEAST ANNUALLY to determine case mix acuity using the ODHS 2220 "Ohio ICF-MR Individual Assessment Form (IAF)".

(B) Effective December 31, 1992 and quarterly thereafter, for each resident of a medicaid-certified ICF-MR bed, regardless of pay source or anticipated length of stay, all medicaid-certified ICFs-MR must submit to the Ohio department of human services (ODHS) an ODHS 2221 "Ohio ICF-MR Individual Assessment Form Answer Sheet" that reflects the resident's condition on the reporting period end date, which is the last day of the calendar quarter. ICFS-MR SHALL EVALUATE AT LEAST QUARTERLY IF A REASSESSMENT IS NECESSARY TO ACCURATELY REFLECT THE RESIDENT'S CURRENT CONDITION.

(1) "Resident of a medicaid-certified ICF-MR as of the reporting period end date" shall include:

(a) Residents who were admitted to the ICF-MR prior to the reporting period end date and continue to be physically present in the ICF-MR on the reporting period end date; and

(b) Residents who were admitted to the ICF-MR on the reporting period end date from a non-ICF-MR setting (home, hospital, adult care facility, rest home, nursing facility (NF)); and

(c) Residents who were transferred or admitted into the ICF-MR from another ICF-MR on the reporting period end date; and

(d) Residents who were temporarily absent on the reporting period

end date but are considered residents due to payment from any source to hold a bed during hospital stays, visits with friends or relatives, or participation in therapeutic programs outside the facility.

(2) "Resident of a medicaid-certified ICF-MR as of the reporting period end date" shall not include residents who were discharged from the ICF-MR, transferred to another ICF-MR, or died prior to or on the reporting period end date.

(3) For admissions occurring within thirteen days prior to the reporting period end date or on the reporting period end date, an assessment will be considered to reflect the resident's condition on the reporting period end date even though the date of assessment may be after the reporting period end date. Such assessments must be conducted no later than fourteen days after the date of admission.

(C) Each provider shall complete and submit QUARTERLY ~~an~~ A SIGNED ODHS 2222 "ICF-MR Certification of IAF Data" form with its quarterly SUBMISSION OF ODHS 2221 forms. The ODHS 2222 form identifies the ICF-MR, medicaid provider number, number of beds certified by the Ohio department of health (ODH) for medicaid, and total number of residents in an ICF-MR as of the reporting period end date, as defined by paragraph (B) of this rule.

(D) The SIGNED ODHS 2222 form and ODHS 2221 forms shall be submitted to ODHS postmarked no later than the fifteenth day of the month following the reporting period end date. The ODHS 2222 form and ODHS 2221 forms shall be submitted in a format that is approved by ODHS. Facilities should retain the original ODHS 2221 for the resident record.

(1) For providers submitting data in paper format, copies of the forms submitted to ODHS must be legible and single-sided. All copies of ODHS 2221 forms from the same provider number and the ODHS 2222 form shall be banded together and submitted at one time IN ONE BOX OR ENVELOPE.